Uniform Form DC14-13
AR4-76

Commonwealth of Massachusetts

TRIAL COURT OF THE COMMONWEALTH
DISTRICT COURT DEPARTMENT
NEW BEDFORD DIVISION

BRISTOL, ss

04-12035-NMG

Civil Action No. 0433 CV 1011

Jo-Ann Soares,
Plaintiff

vs.

Trustmark Insurance Company,
Defendant

ATENÇÃO
Esta é um aviso oficial do Tribunal. Se você não sabe ler inglês, obtenha uma tradução.

SUMMONS
(Rule 4)

To defendant Trustmark Insurance Company (name) of 400 Field Drive, Lake Forest, IL 600 (address)

You are hereby summoned and required to serve upon Thomas P. Crotty, Esquire, plaintiff('s attorney), whose address is 388 County St., New Bedford, MA 02740, a copy of your answer to the complaint which is herewith served upon you, within 20 days after service of this summons, exclusive of the day of service. You are also required to file your answer to the complaint in the office of the Clerk of this court either before service upon plaintiff('s attorney), or within 5 days thereafter. If you fail to meet the above requirements, judgment by default may be rendered against you for the relief demanded in the complaint. You need not appear personally in court to answer the complaint.

Unless otherwise provided by Rule 13(a), your answer must state as a counterclaim any claim which you may have against the plaintiff which arises out of the transaction or occurrence that is the subject matter of the plaintiff's claim or you will be barred from making such claim in any other action.

WITNESS BERNADETTE L. SABRA, Presiding Justice, on August 23, 2004 (date).

(SEAL)

Clerk

Note: (1) When more than one defendant is involved, the names of all defendants should appear in the action. If a separate summons is used for each defendant, each should be addressed to the particular defendant.
(2) The number assigned to the complaint by the Clerk at commencement of the action should be affixed to this summons before it is served.

RETURN OF SERVICE

On August 23, 2004 (date of service), I served a copy of the within summons, together with a copy of the complaint in this action, upon the within named defendant, in the following manner (see Rule 4 (d) (1-5)):

(signature)
Lawrence D. Hunt, Esquire
(name and title)
Perry, Hicks, Crotty & Deshaies, LLP
(address)
388 County Street, New Bedford, MA 027

ATENCION
Esta es una notificación oficial de la corte. Si usted no sabe leer inglés, obtenga traducción.

Note: (1) The person serving the process shall make proof of service thereof in writing to the court and to the party or his attorney, as the case may be, who has requested such service. Proof of service shall be made promptly and in any event within the same time during which the person served must respond to the process. Rule 4(f).
(2) Please place date you make service on defendant in the box on the copy served on the defendant, on the original returned to the court and on the copy returned to the person requesting service or his attorney.
(3) If service is made at the last and usual place of abode, the officer shall forthwith mail first class a copy of the summons to such last and usual place of abode, and shall set forth in the return the date of mailing and the address to which the summons was sent (G.L. c. 223, sec. 11).

This form prescribed by the Chief Justice of the District Courts

COMMONWEALTH OF MASSACHUSETTS

BRISTOL, ss. DISTRICT COURT DEPARTMENT
DOCKET NO. _____

JO-ANN SOARES,
Plaintiff

vs.

TRUSTMARK INSURANCE COMPANY,
Defendant

COMPLAINT

Jo-Ann Soares brings this action against Trustmark Insurance Company to enforce payment of proceeds of a life insurance contract on the life of Manuel Soares. Mrs. Soares is the sole beneficiary of a contract for insurance on the life of Manuel Soares. Mrs. Soares completed the life insurance application in good faith and submitted it to Trustmark. Trustmark has repeatedly denied payment of the claim on the ground that statements in the application for insurance were false, despite its lack of evidence that the statements were willfully false, fraudulent or misleading. See, Torres v. Fidelity & Guaranty Life Insurance Co., 34 Mass. App. Ct. 376 (1993).

PARTIES

1. Plaintiff, Jo-Ann Soares ("Mrs. Soares") is an individual who resides at 29 Sowle Street, New Bedford, Massachusetts.

2. Defendant, Trustmark Insurance Company ("Trustmark") is a corporation with a usual place of business at 400 Field Drive, Lake Forest, Illinois.

FACTS

3. On October 29, 2002, Mrs. Soares submitted an application to Trustmark for a life insurance policy on the life of Manuel Soares. A copy of that application is attached hereto as Exhibit A.

4. Among the information requested by the application was whether Mr. Soares had been treated in the six months prior to the application for an illness or disease (question 9 on application). Mrs. Soares answered the question in the negative, based upon information given to her by Mr. Soares. Unbeknownst to Mrs. Soares, Mr. Soares had seen physicians for treatment within the six months prior, in July and August of 2002.

5. Mrs. Soares completed this application in good faith based on Mrs. Soares' best memory and information available to her.

6. Trustmark issued policy number WT9714 in response to this application (the "Policy"). Mrs. Soares began paying premiums on the policy and continued to do so during the life of Mr. Soares. The face amount of that policy is $20,000. A copy of that policy is attached hereto as Exhibit B.

7. Trustmark issued the policy on the life of Manuel Soares without requiring a medical examination of Mr. Soares.

8. The policy provides for adjustments to the death benefit amount due to misstatements of age and allows for rescission as to misstatements of cigarette use. The policy contains no provision on its face with regard to other misstatements, (page 13 of policy).

9. Mrs. Soares is the sole beneficiary under the policy.

10. Mr. Soares died on February 14, 2003.

11. Mrs. Soares submitted a claim for benefits on the policy on June 24, 2003.

12. Trustmark denied the claim on February 4, 2004, and sent Mrs. Soares a check in the amount of $250.99 for reimbursement for premiums paid on the policy. A copy of that denial is attached hereto as Exhibit C.

13. Trustmark's initial reasoning for denial of the claim, as stated in their February 4, 2004 denial was that Mrs. Soares made a material misrepresentation in her application when she stated that Mr. Soares had not seen a doctor within the prior six months.

14. "Material misrepresentation" is not a valid ground for denial of death benefits. Under Massachusetts law, where an insurance company chooses to issue a policy without a medical examination of the insured, the company may deny a claim only where the company proves that the statements in the application are "willfully false, fraudulent, or misleading." Mass. Gen. Laws, Ch. 175 §124; Torres v. Fidelity & Guaranty Life, 34 Mass. App. Ct. 376 (1993).

15. Mrs. Soares again made demand for payment of the claim on May 12, 2004. A copy of that demand is attached hereto as Exhibit D.

16. On May 27, 2004, Trustmark recognized their affirmative obligation to prove that the statement was "willfully false, fraudulent or misleading," but again denied the claim. The second denial was made on the claimed belief that the misrepresentation was willfully false, fraudulent or misleading, with no offer of proof and without any investigation. A copy of that correspondence is attached as Exhibit E.

COUNT I

Breach of Contract

17. Plaintiff, Jo-Ann Soares, repeats the allegations set forth in paragraphs 1 through 16 as though the same were fully set forth herein.

18. Mrs. Soares tendered performance under the contract for life insurance by paying premiums on the policy.

19. Trustmark breached the contract by refusing to pay the claim.

Wherefore, Plaintiff, Jo-Ann Soares, prays that this Court:

a. Ender judgment in the amount of $20,000, plus interest, against the defendant, Trustmark Insurance Company, together with costs and attorneys fees.

b. Grant Plaintiff such other and further relief as this Court deems just and proper.

COUNT II

M.G.L. chapter 93A

20. Plaintiff, Jo-Ann Soares, repeats the allegations set forth in paragraphs 1 through 19 as though the same were fully set forth herein.

21. On June 2, 2004, Mrs. Soares sent a demand letter in accordance with M.G.L. chapter 93A to Trustmark. A copy of that demand is attached hereto as Exhibit F. In its response, Trustmark failed to make a reasonable offer of settlement. A copy of that response is attached hereto as Exhibit G.

22. Trustmark has engaged in unfair claims settlement practices under M.G.L. ch. 176D §3(9), undertaken willfully and knowingly, by "refusing to pay claims without conducting a reasonable investigation based upon all available information;" by "failing to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;" and by "compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds." Mass. Gen. L. Ch. 176D, §3(9).

23. These unfair claims settlement practices are violations of the Massachusetts Consumer Protection Law, M.G.L. ch.93A.

Wherefore, Plaintiff, Jo-Ann Soares, prays that this Court:

a. Enter judgment in the amount of $20,000 against the Defendant Trustmark, and in additional to actual damages, award the Plaintiff $40,000, plus interest, plus costs of suit herein including attorneys' fees.

b. Grant Plaintiff such other and further relief as this Court deems just and proper.

Plaintiff, Jo-Ann Soares,
By Her Attorney,

Thomas P. Crotty, Esquire BBO#106800
Lawrence D. Hunt, Esquire BBO#643821
Perry, Hicks, Crotty & Deshaies, LLP
388 County Street
New Bedford, MA 02740
508-996-8291

TRUSTMARK INS... E COMPANY Application for: ☒ Life Coverage ☐ ...ritical Illness Coverage
400 Field Drive, Lake Forest, IL 60045 ☐ Increase to Existing Policy # _____
Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

SECTION A. APPLICANT INFORMATION

Employer: CITY OF NEW BEDFORD | Employee I.D. #: | Annual Salary: $ 40000
Location: WATER/WASTEWATER | Department: | Email Address WT9714
Social Security No. 030-38-6321 | Date of Hire: 2/1985 | Home Phone No. 508 995-2532
Employee: JO-ANN SOARES | Birth Date: 3/19/51 | Sex: ☐ M ☒ F | Deduction ☐ 52 ☐ 26 ☐ 24 ☐ 20 Mode: ☐ 12 ☐ 11 ☐ 10 ☒ 48
Home Address: (Street) 29 SOWLE ST | (City) NEW BEDFORD | (State) MA | (Zip) 02745

SECTION B. LIFE INSURANCE Complete Questions 1 through 11. Answers to these questions apply to both the Proposed Insureds and all Dependent Children for whom coverage is applied.

1. Proposed Insured #1 E☐ S☒ C☐ G☐ ☒ M ☐ F — MANUEL P. SOARES, JR.	1a. Proposed Insured #1a E☐ S☐ C☐ G☐ ☐ M ☐ F
2. Birth Date 7/4/36 | Age 66 | Birth State MA | Height 5'2" | Weight 125	2. Birth Date | Age | Birth State | Height | Weight
3. Plan: ☒ Universal Life ☐ Term ☐ Other ___ ☐ Increase to Policy/Certificate # _____	3. Plan: ☐ Universal Life ☐ Term ☐ Other ___ ☐ Increase to Policy/Certificate # _____
4. Riders: ☐ HH/LTC ☒ ADB ☐ BRR ☐ CIR ☐ EOB ☐ BRR/EOB ☐ LWS ☐ WP ☐ ___ ☐ ___	4a. Riders: ☐ HH/LTC ☐ ADB ☐ BRR ☐ CIR ☐ EOB ☐ BRR/EOB ☐ LWS ☐ WP ☐ ___ ☐ ___
5. ☒ Amount of Insurance $ 70,000 or ☒ Amount purchased by premium payment of $ 15.69 (including riders) ☐ Other Insured Term Rider - Amount of $ _____ ☐ EZ Value Plan - ☐ $1/week increase for the first: ☐ 5 years ☐ 10 years or ☐ $2/week increase for the first 5 years — UL Death Benefit Option ☒ A (Level) ☐ B (Increasing)	5a. ☐ Amount of Insurance $ _____ or ☐ Amount purchased by premium payment of $ _____ / _____ (including riders) ☐ Other Insured Term Rider - Amount of $ _____ ☐ EZ Value Plan - ☐ $1/week increase for the first: ☐ 5 years ☐ 10 years or ☐ $2/week increase for the first 5 years — UL Death Benefit Option ☐ A (Level) ☐ B (Increasing)
6. Name/relationship of Beneficiary (Prop. Insured #1) JO-ANN SOARES - SPOUSE	6a. Name/relationship of Beneficiary (Prop. Insured #1a)

7. ☐ Children's Term Insurance Rider. (CT). ☐ $5,000 ☐ $10,000. List all unmarried dependent children who are under age 19 and proposed for coverage. Children's Term Insurance Rider is part of the coverage on the life of ☐ Proposed Insured #1 or ☐ Proposed Insured #1a. Use the Remarks Box or separate sheet of paper, if necessary.

First Name	MI	Last Name	Birth Date	Relationship

	Employee Yes	Employee No	Spouse Yes	Spouse No	Dependent Children Yes	Dependent Children No
8. Does anyone proposed for coverage smoke cigarettes or during the past 12 months has anyone proposed for coverage smoked cigarettes?	☐	☒	☐	☐	☐	☐
9. Is any person to be insured now disabled, been seen by a physician or treated in a medical facility, including a doctor's office, within the last 6 months for illness or disease (other than flu and colds)?	☐	☒	☐	☐	☐	☐
10. Has any person to be insured been treated for, or diagnosed by a member of the medical profession as having, Acquired Immune Deficiency Syndrome (AIDS) or tested positive on an AIDS or HIV (Human Immunodeficiency Virus) test? If yes, to either question 9 or 10, questions 12 and 13 must be completed.	☐	☒	☐	☐	☐	☐
11. Will this insurance replace, in whole or in part, any life, accident and sickness, long-term care insurance or annuity? If yes, provide name of company and amount of insurance under "Remarks or Special Requests."	☐	☒	☐	☐	☐	☐

Give details of any "Yes" answer to questions 9 or 10 in Question 19. Include the name of the person.

If Application is Simplified Issue, Complete 12 and 13 and Sign the Other Side of the Application.

12. Has any person to be insured:	Employee Yes	Employee No	Spouse Yes	Spouse No	Dependent Children Yes	Dependent Children No
a. Had, within the past 5 years: heart disease; chest pains; high blood pressure; stroke; diabetes; cancer; tumor; kidney disease; blood disorder (excluding any testing for HIV antibodies); liver disease; lung disease; or other known health impairments?	☐	☒	☐	☐	☐	☐
b. Within the past 10 years received medical treatment or counseling, or participated in a rehabilitation program, for alcohol or drug abuse?	☐	☒	☐	☐	☐	☐
c. Seen a medical practitioner in the past 12 months for anything other than a routine physical examination?	☐	☒	☐	☐	☐	☐

13. If you answered "YES" to questions 9, 10 or any part of question 12, give details in question 19.

I represent all statements and answers given in this application about me or my Dependents are complete and true. I agree that all such statements and answers shall be made a part of any insurance issued. Under penalties of perjury, I certify: (1) that the Social Security number shown above is correct; and (2) the IRS has not told me that I am subject to backup withholding. [Coverage is provided under a policy issued to a trust.] I understand that: 1) the insurance will be effective on the date assigned by Trustmark; and 2) I must be actively at work at my employer named above on the first premium payroll deduction date, to be eligible for insurance. I certify that I received no illustration in the sale of this life insurance Policy/Certificate. I understand that an illustration conforming to the Policy/Certificate as issued will be provided no later than at the time of Policy/Certificate delivery.

Agent's Statement: To the best of your knowledge, will this insurance replace any existing life, accident and sickness, long-term care insurance or annuity?
☐ Yes ☒ No (Proposed Insured #1)
☐ Yes ☐ No (Proposed Insured #1a)
I certify that no illustration was used in the sale of this life insurance Policy/Certificate.

MICHAEL DAVEY
Printed Name of Writing Agent
Signature of Agent — Agent I.D. Number NF93

Signed at (city and state) NEW BEDFORD, MA on (month/day/year) 10/29/03

X _____ Signature of Proposed Insured #1

X _____ Signature of Proposed Insured #1a

X _____ Signature(s) of Owner, if other than Proposed Insured

CL-801 MA WP

WT9714P1

EXHIBIT A

Trustmark
INSURANCE COMPANY

Dear Certificateholder/Policyholder:

We are pleased to announce a number of enhancements to your Trustmark Premier Protector Universal Life coverage as of March 6, 2002.

You may notice these enhancements in one of three ways.

1. You may notice a higher death benefit in your issued coverage than what was reviewed at time of application.
2. You may notice higher account and cash values in your issued coverage than what was reviewed at the time of application.
3. You may have already seen these enhancements in the values that were reviewed at the time of application.

In all cases, these enhancements increased the value of your coverage and were included at no additional cost. Your deduction remains the same.

These enhancements are also in effect for all previously issued Premier Protector coverage, which will have higher account and cash values as a result.

If you have any questions for our Client Service Department, just call 1-800-918-8877. Our staff is available to answer questions or perform any other related services you may need.

Thank you for your confidence in us. We look forward to serving you for many years to come.

Sincerely,

Client Services

Trustmark
INSURANCE COMPANY

400 Field Drive • Lake Forest, IL 60045
Phone: (800) 918-8877 • Fax: (847) 615-3826

JOANN SOARES
29 SOWLE ST
NEW BEDFORD MA 02745

Certificate Number: WT9714
Proposed Insured: MANUEL P SOARES JR
Employer: CITY OF NEW BEDFORD

Dear Insured:

Congratulations and thank you for participating in the Massachusetts Municipal Insurance Program underwritten by Trustmark Insurance Company. The Trustmark **Protector** made available to you through your employer will mean added security for you and your family.

Enclosed please find your Trustmark **Protector** Plan documents. Please review and store them in a safe place for future reference. We have also enclosed two copies of your Life Insurance Illustration **Numeric Summary. Please sign and return one copy in the enclosed postage paid envelope.**

It is very important that you contact the office of the Massachusetts Municipal Insurance Program if you should change your name, address, or employer. Remember, your coverage is portable, it may be continued if you residence or employment status change.

Thank you again. If you should have any questions, please do not hesitate to call your servicing agent, the Massachusetts Municipal Insurance Program at (800) 445-4493, or our office at (800) 918-8877, option 8.

Sincerely,
Trustmark Insurance Company
Massachusetts Municipal Administration Team

Enclosures

EXHIBIT
tabbies
B

SECTION C. CANCER/CRITICAL ILLNESS INSURANCE Complete Questions 14 thru 19. Answers to these questions apply to both the Proposed Insureds and all Dependent Children for whom coverage is applied.

14. Proposed insureds: ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Employee, Spouse & Children
List Spouse and dependent children under age 24 proposed for coverage below, and indicate whether any of the proposed insureds have smoked cigarettes or used tobacco in any form within the last 12 months.

First Name	MI	Last Name	Birth Date	Relationship	Tobacco Usage
Employee			/ /		☐ Yes ☐ No
			/ /		☐ Yes ☐ No
			/ /		☐ Yes ☐ No
			/ /		☐ Yes ☐ No

15. ☐ Critical Illness – Only (CI)
☐ LWS ☐ WP ☐ ROP ☐ ROP/SV
HSB: ☐ $50 or ☐ $100 ☐_____
☐ EZ Value Plan $1/wk. increase in premium applied to the Benefit at each of the next 5 policy anniversaries.
☐ Lifetime Pay ☐ 20 Year Paid Up
Benefit $ _____
Premium $ _____

☐ Cancer – Only (CA)
☐ LWS ☐ WP ☐ ROP ☐ ROP/SV
HSB: ☐ $50 or ☐ $100 ☐_____
☐ EZ Value Plan $1/wk. increase in premium applied to the Benefit at each of the next 5 policy anniversaries.
☐ Lifetime Pay ☐ 20 Year Paid Up
Benefit $ _____
Premium $ _____

☐ Critical Illness/Cancer Combo (Single Benefit)
☐ LWS ☐ WP ☐ ROP ☐ ROP/SV
HSB: ☐ $50 or ☐ $100 ☐_____
☐ EZ Value Plan $1/wk. increase in premium applied to the Benefit at each of the next 5 policy anniversaries.
☐ Lifetime Pay ☐ 20 Year Paid Up
Benefit $ _____
Premium $ _____

Benefit amount in the first Policy/Certificate year is 50% of the Benefit Amount applied for.

16. a. As of the date of this application, does the Insured and/or proposed insured have in force or an application pending for another specified disease policy? ☐ Yes ☐ No
b. Are all persons to be insured currently covered under at least Major Medical, or at least basic hospital and basic medical coverage? ☐ Yes ☐ No

	Employee		Spouse		Dependent Children	
	Yes	No	Yes	No	Yes	No
17. In the past 10 years, has any proposed insured been: (1) recommended by a member of the medical profession to have diagnostic tests related to cancer which have not yet been performed or for which results have not yet been received (excluding routine periodic mammogram, pap smears, and/or PSA tests); or (2) diagnosed as having, or been treated for: Cancer, including skin Cancer (excluding basal cell carcinoma); Hodgkin's Disease; or Leukemia, Lymphoma, or Multiple Myeloma; or a Brain Tumor or Growth?	☐	☐	☐	☐	☐	☐
18. Has any proposed insured been treated for, or diagnosed by a member of the medical profession as having, Acquired Immunodeficiency Syndrome (AIDS) or tested positive on an AIDS test or any other immune system deficiency test?	☐	☐	☐	☐	☐	☐
19. CRITICAL ILLNESS COVERAGE: Does any proposed insured now have, or ever been diagnosed as having, or been treated for: TIA or stroke; bleeding disorder(s); any neurological disease or disorder, including but not limited to ALS (Lou Gehrig's Disease) and multiple sclerosis, or any disease or disorder of the lungs; pancreas (including diabetes); kidneys; liver; heart and/or circulatory system; or high blood pressure with readings at or above 150MM.HG Systolic Blood Pressure and/or 100 MM.HG Diastolic Blood Pressure?	☐	☐	☐	☐	☐	☐

19. If you answered "Yes" to Questions 17, 18 or 19 give details below:

Question	Person to whom it applies	Illness/Injury/Details	Date of Last Visit	Doctor's Name/Address/Phone

SECTION D. CONDITIONAL AMENDMENTS TO APPLICATION

	Yes	No
I hereby authorize Trustmark to issue Cancer coverage instead of the Critical Illness/Cancer Combination (Single Benefit) coverage on any of the proposed insureds who are declined for the Critical Illness coverage.	☐	☐
I hereby authorize Trustmark to issue a lesser benefit amount of coverage than applied for if any of the proposed insureds are declined for the dollar amount applied for.	☐	☐
If any of the proposed insureds for coverage are declined, then I hereby authorize Trustmark to issue coverage on the remaining proposed insureds acceptable to Trustmark.	☐	☐
If coverage is not issued as initially applied for, I hereby authorize Trustmark to decrease or increase the premium amount stated on this application to cover the benefit actually issued to the persons actually insured.	☐	☐

NOTE: None of the above conditional amendments create any additional obligation by Trustmark to issue coverage to any proposed insured.

Remarks or Special Requests

I represent that all statements and answers given in this application are complete and true. I agree that all such statements and answers shall be made part of any insurance issued.
Acknowledgment - I have received and read a copy of the Company's Notices about: 1) Fair Credit Reporting Act; 2) the Medical Information Bureau; and 3) the Notice of Information Practices.
Trustmark Insurance Company is authorized to obtain an investigative Consumer report on me. I understand that I may ask to be interviewed for this report.
Authorization to Release Information - I authorize the entities listed herein to give Trustmark Insurance Company, and through it, to its reinsurers and the Medical Information Bureau any data or records in the entities possession about me or my mental or physical health. This applies to data or records about my spouse and any child proposed for insurance in this application. This authorization is for: any medical practitioner; hospital; clinic or other medically related facility; insurance company; the Medical Information Bureau; or other organization, institution, or person which may have information pertinent to determine my eligibility for insurance. This authorization is valid for two years and six months from the date of this authorization. A photographic or facsimile copy of this form will be as valid as the original. (The person who signs this form may have a copy of it upon request.)

Signed at (city and state) _____ on (month/day/year) _____

X _____ X _____
Signature of Proposed Insured | Signature(s) of Owner, if other than Proposed Insured

Printed Name of Writing Agent | Signature of Agent Agent I.D. Number

For Home Office Use Only

CL-801 MA WP

WT9714P2

TRUSTMARK INSURANCE COMPANY
400 Field Drive
Lake Forest, Illinois 60045

CERTIFICATE OF INSURANCE

This is Your Certificate of Insurance ("Certificate") while the Group Policy ("Policy") is in force. It explains the rights and benefits that are determined by the Policy. The Policy is a contract between the Policyholder and Us. The Policy is issued to the Starmark MI Trust as Policyholder.

We will pay the Death Benefit Proceeds to the Beneficiary if the Insured dies prior to the Maturity Date and while this Certificate is in force. Payment will be made after We receive due proof of the Insured's death. We will pay the Cash Value of this Certificate to the Owner on the Certificate Maturity Date if the Insured is living on that date. Payment is subject to the terms of the Policy and this Certificate.

NOTICE OF THIRTY DAY RIGHT TO EXAMINE

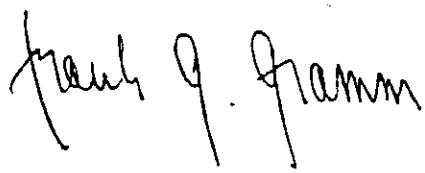
You may return this Certificate within thirty days after delivery if You are not satisfied with it for any reason. The Certificate may be returned to Us or to the agent through whom it was purchased. Upon surrender of the Certificate within the thirty day period, it will be void from the beginning, and We will refund any premium paid.

The provisions on the pages which follow are a part of this Certificate. This Certificate contains a summary of the terms of the Group Policy which is a legal contract between the Policyholder and Us. This Certificate is evidence of life insurance under the Group Policy and is subject to all of the terms and limits of the Group Policy and any amendments thereto.

Read Your Certificate Carefully.

TRUSTMARK INSURANCE COMPANY

J. Grover Thomas Jr.
President & Chief Executive Officer



Frank G. Gramm
Corporate Secretary & General Counsel

Flexible Premium Adjustable Life Insurance to Age 100. Adjustable Death Benefit Proceeds payable upon the Insured's death prior to the Maturity Date. Flexible premiums are payable during the lifetime of the Insured prior to age 100, and while the Certificate is in force. Accumulated Values and Cash Values are flexible and will be based on the amount and frequency of premiums paid, the Monthly Deduction, and the amount of interest credited. Participating.

VULXXCV40000

TABLE OF CONTENTS

TRUSTMARK INS E COMPANY Application for: ☒ Life Coverage ☐ C ritical Illness Coverage
400 Field Drive, La orest, IL 60045 ☐ Increase to Existin icy #
Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

SECTION A. APPLICANT INFORMATION

Employer: CITY OF NEW BEDFORD | Employee I.D. #: | Annual Salary: $ 40000
Location: WATER/WASTEWATER | Department: | Email Address WT9714
Social Security No. 030-78-6321 | Date of Hire: 8-1985 | Home Phone No. 508-995-2532
Employee: JO-ANN SOARES | Birth Date: 3/18/51 | Sex: ☐ M ☒ F | Deduction ☐ 52 ☐ 26 ☐ 24 ☐ 20 ☒ 48 | Mode: ☐ 12 ☐ 11 ☐ 10 ☒
Home Address: (Street) 29 ~~Seal~~ SOWLE ST (City) NEW BEDFORD (State) MA (Zip) 02745

SECTION B. LIFE INSURANCE Complete Questions 1 through 11. Answers to these questions apply to both the Proposed Insureds and all Dependent Children for whom coverage is applied.

	Proposed Insured #1	Proposed Insured #1a
1. Proposed Insured	E ☐ S ☒ C ☐ G ☐ ☒ M ☐ F — MANUEL P. SOARES, JR.	E ☐ S ☐ C ☐ G ☐ ☐ M ☐ F
2. Birth Date / Age / Birth State / Height / Weight	7/21/36 / 68 / MA / 5'7" / 135	2. Birth Date / Age / Birth State / Height / Weight
3. Plan:	☒ Universal Life ☐ Term ☐ Other ☐ Increase to Policy/Certificate #	3. Plan: ☐ Universal Life ☐ Term ☐ Other ☐ Increase to Policy/Certificate #
4. Riders:	☐ HH/LTC ☒ ADB ☐ BRR ☐ CIR ☐ EOB ☐ BRR/EOB ☐ LWS ☐ WP ☐ ☐	4a. Riders: ☐ HH/LTC ☐ ADB ☐ BRR ☐ CIR ☐ EOB ☐ BRR/EOB ☐ LWS ☐ WP ☐ ☐
5.	☒ Amount of Insurance $ 70000 or ☒ Amount purchased by premium payment of $ 45.69 (including riders) ☐ Other Insured Term Rider - Amount of $ ☐ EZ Value Plan - ☐ $1/week increase for the first: ☐ 5 years ☐ 10 years or ☐ $2/week increase for the first 5 years	UL Death Benefit Option ☒ A (Level) ☐ B (Increasing)
5a.	☐ Amount of Insurance $ or ☐ Amount purchased by premium payment of $ (including riders) ☐ Other Insured Term Rider - Amount of $ ☐ EZ Value Plan - ☐ $1/week increase for the first: ☐ 5 years ☐ 10 years or ☐ $2/week increase for the first 5 years	UL Death Benefit Option ☐ A(Level) ☐ B (Increasing)
6. Name/relationship of Beneficiary (Prop. Insured #1)	JO-ANN SOARES - SPOUSE	6a. Name/relationship of Beneficiary (Prop. Insured #1a)

7. ☐ Children's Term Insurance Rider. (CT). ☐ $5,000 ☐ $10,000. List all unmarried dependent children who are under age 19 and proposed for coverage. Children's Term Insurance Rider is part of the coverage on the life of ☐ Proposed Insured #1 or ☐ Proposed Insured #1a. Use the Remarks Box or separate sheet of paper, if necessary.

First Name	MI	Last Name	Birth Date	Relationship

	Employee Yes	Employee No	Spouse Yes	Spouse No	Dependent Children Yes	Dependent Children No
8. Does anyone proposed for coverage smoke cigarettes or during the past 12 months has anyone proposed for coverage smoked cigarettes?	☐	☒	☐	☐	☐	☐
9. Is any person to be insured now disabled, been seen by a physician or treated in a medical facility, including a doctor's office, within the last 6 months for illness or disease (other than flu and colds)?	☐	☒	☐	☐	☐	☐
10. Has any person to be insured been treated for, or diagnosed by a member of the medical profession as having, Acquired Immune Deficiency Syndrome (AIDS) or tested positive on an AIDS or HIV (Human Immunodeficiency Virus) test? If yes, to either question 9 or 10, questions 12 and 13 must be completed.	☐	☒	☐	☐	☐	☐
11. Will this insurance replace, in whole or in part, any life, accident and sickness, long-term care insurance or annuity? If yes, provide name of company and amount of insurance under "Remarks or Special Requests."	☐	☒	☐	☐	☐	☐

Give details of any "Yes" answer to questions 9 or 10 in Question 19. Include the name of the person.

If Application is Simplified Issue, Complete 12 and 13 and Sign the Other Side of the Application.

12. Has any person to be insured:	Employee Yes	Employee No	Spouse Yes	Spouse No	Dependent Children Yes	Dependent Children No
a. Had, within the past 5 years: heart disease; chest pains; high blood pressure; stroke; diabetes; cancer; tumor; kidney disease; blood disorder (excluding any testing for HIV antibodies); liver disease; lung disease; or other known health impairments?	☐	☒	☐	☐	☐	☐
b. Within the past 10 years received medical treatment or counseling, or participated in a rehabilitation program, for alcohol or drug abuse?	☐	☒	☐	☐	☐	☐
c. Seen a medical practitioner in the past 12 months for anything other than a routine physical examination?	☐	☒	☐	☐	☐	☐

13. If you answered "YES" to questions 9, 10 or any part of question 12, give details in question 19.

I represent all statements and answers given in this application about me or my Dependents are complete and true. I agree that all such statements and answers shall be made a part of any insurance issued. Under penalties of perjury, I certify: (1) that the Social Security number shown above is correct; and (2) the IRS has not told me that I am subject to backup withholding. [Coverage is provided under a policy issued to a trust.] I understand that: 1) the insurance will be effective on the date assigned by Trustmark; and 2) I must be actively at work at my employer named above on the first premium payroll deduction date, to be eligible for insurance. I certify that I received no illustration in the sale of this life insurance Policy/Certificate. I understand that an Illustration conforming to the Policy/Certificate as issued will be provided no later than at the time of Policy/Certificate delivery.

Agent's Statement: To the best of your knowledge, will this insurance replace any existing life, accident and sickness, long-term care insurance or annuity?
☐ Yes ☒ No (Proposed Insured #1)
☐ Yes ☐ No (Proposed Insured #1a)
I certify that no illustration was used in the sale of this life insurance Policy/Certificate.

MICHAEL DAVEY
Printed Name of Writing Agent
Davey MF93
Signature of Agent — Agent I.D. Number

Signed at (city and state) NEW BEDFORD, MA on (month/day/year) 10/29/05

X _____ Signature of Proposed Insured #1

X _____ Signature of Proposed Insured #1a

X _____ Signature(s) of Owner, if other than Proposed Insured

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SECTION C. CANCER [illegible]TICAL ILLNESS INSURANCE Complete Questions 14 thr[illegible] 19. Answers to these questions apply to both the Proposed Insureds and all Dependent Children for whom coverage is applied.

14. Proposed Insureds: ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Employee, Spouse & Children
List Spouse and dependent children under age 24 proposed for coverage below, and indicate whether any of the proposed insureds have smoked cigarettes or used tobacco in any form within the last 12 months.

First Name	MI	Last Name	Birth Date	Relationship	Tobacco Usage
Employee			/ /		☐ Yes ☐ No
			/ /		☐ Yes ☐ No
			/ /		☐ Yes ☐ No
			/ /		☐ Yes ☐ No

15. ☐ Critical Illness – Only (CI)
☐ LWS ☐ WP ☐ ROP ☐ ROP/SV
HSB: ☐ $50 or ☐ $100 ☐_____
☐ EZ Value Plan $1/wk. increase in premium applied to the Benefit at each of the next 5 policy anniversaries.
☐ Lifetime Pay ☐ 20 Year Paid Up
Benefit $ _____
Premium $ _____

☐ Cancer – Only (CA)
☐ LWS ☐ WP ☐ ROP ☐ ROP/SV
HSB: ☐ $50 or ☐ $100 ☐_____
☐ EZ Value Plan $1/wk. increase in premium applied to the Benefit at each of the next 5 policy anniversaries.
☐ Lifetime Pay ☐ 20 Year Paid Up
Benefit $ _____
Premium $ _____

☐ Critical Illness/Cancer Combo (Single Benefit)
☐ LWS ☐ WP ☐ ROP ☐ ROP/SV
HSB: ☐ $50 or ☐ $100 ☐_____
☐ EZ Value Plan $1/wk. increase in premium applied to the Benefit at each of the next 5 policy anniversaries.
☐ Lifetime Pay ☐ 20 Year Paid Up
Benefit $ _____
Premium $ _____

Benefit amount in the first Policy/Certificate year is 50% of the Benefit Amount applied for.

16. a. As of the date of this application, does the Insured and/or proposed insured have in force or an application pending for another specified disease policy? ☐ Yes ☐ No
b. Are all persons to be insured currently covered under at least Major Medical, or at least basic hospital and basic medical coverage? ☐ Yes ☐ No

	Employee		Spouse		Dependent Children	
	Yes	No	Yes	No	Yes	No
17. In the past 10 years, has any proposed insured been: (1) recommended by a member of the medical profession to have diagnostic tests related to cancer which have not yet been performed or for which results have not yet been received (excluding routine periodic mammogram, pap smears, and/or PSA tests); or (2) diagnosed as having, or been treated for: Cancer, including skin Cancer (excluding basal cell carcinoma); Hodgkin's Disease; or Leukemia, Lymphoma, or Multiple Myeloma; or a Brain Tumor or Growth?	☐	☐	☐	☐	☐	☐
18. Has any proposed insured been treated for, or diagnosed by a member of the medical profession as having, Acquired Immunodeficiency Syndrome (AIDS) or tested positive on an AIDS test or any other immune system deficiency test?	☐	☐	☐	☐	☐	☐
19. CRITICAL ILLNESS COVERAGE: Does any proposed insured now have, or ever been diagnosed as having, or been treated for: TIA or stroke; bleeding disorder(s); any neurological disease or disorder, including but not limited to ALS (Lou Gehrig's Disease) and multiple sclerosis, or any disease or disorder of the lungs; pancreas (including diabetes); kidneys; liver; heart and/or circulatory system; or high blood pressure with readings at or above 150MM.HG Systolic Blood Pressure and/or 100 MM.HG Diastolic Blood Pressure?	☐	☐	☐	☐	☐	☐

19. If you answered "Yes" to Questions 17, 18 or 19 give details below:

Question	Person to whom it applies	Illness/Injury/Details	Date of Last Visit	Doctor's Name/Address/Phone

SECTION D. CONDITIONAL AMENDMENTS TO APPLICATION

	Yes	No
I hereby authorize Trustmark to issue Cancer coverage instead of the Critical Illness/Cancer Combination (Single Benefit) coverage on any of the proposed insureds who are declined for the Critical Illness coverage.	☐	☐
I hereby authorize Trustmark to issue a lesser benefit amount of coverage than applied for if any of the proposed insureds are declined for the dollar amount applied for.	☐	☐
If any of the proposed insureds for coverage are declined, then I hereby authorize Trustmark to issue coverage on the remaining proposed insureds acceptable to Trustmark.	☐	☐
If coverage is not issued as initially applied for, I hereby authorize Trustmark to decrease or increase the premium amount stated on this application to cover the benefit actually issued to the persons actually insured.	☐	☐

NOTE: None of the above conditional amendments create any additional obligation by Trustmark to issue coverage to any proposed insured.

Remarks or Special Requests

I represent that all statements and answers given in this application are complete and true. I agree that all such statements and answers shall be made part of any insurance issued.
Acknowledgment - I have received and read a copy of the Company's Notices about: 1) Fair Credit Reporting Act; 2) the Medical Information Bureau; and 3) the Notice of Information Practices.
Trustmark Insurance Company is authorized to obtain an Investigative Consumer report on me. I understand that I may ask to be interviewed for this report.
Authorization to Release Information - I authorize the entities listed herein to give Trustmark Insurance Company, and through it, to its reinsurers and the Medical Information Bureau any data or records in the entities' possession about me or my mental or physical health. This applies to data or records about my spouse and any child proposed for insurance in this application. This authorization is for: any medical practitioner; hospital; clinic or other medically related facility; insurance company; the Medical Information Bureau; or other organization, institution, or person which may have information pertinent to determine my eligibility for insurance. This authorization is valid for two years and six months from the date of this authorization. A photographic or facsimile copy of this form will be as valid as the original. (The person who signs this form may have a copy of it upon request.)

Signed at (city and state) _____ on (month/day/year) _____

X _____ X _____
Signature of Proposed Insured — Signature(s) of Owner, if other than Proposed Insured

Printed Name of Writing Agent — Signature of Agent Agent I.D. Number

For Home Office Use Only

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WT9714P2

SCHEDULE

INSURED: MANUEL P SOARES JR

AGE: 66

RATE CLASS: PREFERRED

INITIAL FACE AMOUNT: $ 20,000

DEATH BENEFIT OPTION: A

FACE AMOUNT INCREASE:

PERCENTAGE RATING FACTOR: 1.1000

CERTIFICATE NUMBER: WT9714

CERTIFICATE DATE: JANUARY 01, 2003

MATURITY DATE: JANUARY 01, 2037

REGULAR MONTHLY PREMIUM: $62.76

MONTHLY GUARANTEE PREMIUM: $62.76

MONTHLY GUARANTEE PREMIUM EXPIRY DATE: JANUARY 01, 2008

OWNER AND BENEFICIARY AS DESIGNATED IN THE APPLICATION UNLESS SUBSEQUENTLY CHANGED AS HEREIN PROVIDED

BASIC CERTIFICATE DATA

FORM NO.	BENEFIT	INITIAL PLANNED ANNUAL PREMIUM	EXPIRY DATE
GUL-899	Flexible Premium Adjustable Life Ins.	$753.12	JANUARY 01, 2037
	Riders		
	Total Initial Planned Premium		
	Annual	$753.12	
	Monthly	$62.76	
	Initial Surrender Charge	$ 1,057.00	

SCHEDULE (Continued)

IMPORTANT FINANCIAL INFORMATION

GUARANTEED MINIMUM INTEREST RATE:	4.0% COMPOUNDED YEARLY
MONTHLY ADMINISTRATIVE FEE:	$5.50
PARTIAL WITHDRAWAL CHARGE:	$25.00 FOR EACH PARTIAL WITHDRAWAL
LOAN INTEREST RATE:	8% COMPOUNDED YEARLY
PERCENTAGE EXPENSE CHARGE:	CERTIFICATE YEARS 1 THROUGH 10:
	10.0% OF PREMIUM PAID UP TO THE REGULAR ANNUAL PREMIUM
	CERTIFICATE YEARS 11 AND AFTER:
	06.0% OF PREMIUM PAID UP TO THE REGULAR ANNUAL PREMIUM.

SURRENDER CHARGE: SHOWN AS A PERCENT OF THE INITIAL SURRENDER CHARGE

CERTIFICATE YEAR	PERCENT
1	96%
2	95%
3	94%
4	90%
5	85%
6	80%
7	75%
8	70%
9	60%
10	50%
11	40%
12	30%
13	20%
14	10%
15	0%
16	0%
17	0%
18	0%
19	0%
20	0%

VULXXSB40000

#1

AMENDMENT

INSURED: MANUEL P. SOARES JR
POLICY/CERTIFICATE NO: WT9714

This Policy/Certificate has been amended as follows:

The ADB RIDER is hereby removed due to age limits.

This amendment will be effective as of October 29, 2002. Except as stated herein, this amendment will not change any of the terms or provisions of the Policy/Certificate.

TRUSTMARK
INSURANCE COMPANY (MUTUAL)

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